January 19, 2016

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

Eileen Fleck
Chief, Acute Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Eileen.fleck@maryland.gov

Dear Ms. Fleck:

Anne Arundel Medical Center (AAMC) is grateful for the opportunity to provide comments on the Draft State Health Plan for Facilities and Services: Freestanding Medical Facilities (COMAR 10.24.19) (the "Draft Chapter") during the informal public comment period. As recognized by the Maryland Health Care Commission and its staff, the utilization and expansion of hospital emergency departments in Maryland over the 18 year period 1995-2013 has resulted in less than optimal care for patients. Alternative models of care such as urgent or immediate care, as well as the lack of access to primary care and emergency services, have made it necessary and prudent to develop policies and standards for assuring high quality, low cost, accessible health care for all Marylanders.

AAMC is the state's third busiest hospital as measured by patient discharges.[1] Also, AAMC is in the top quartile of Maryland hospitals for number of emergency department visits.[2] We are committed to our vision of helping our patients and their families live healthier lives and to be able to access appropriate health care at the right location and in a timely manner. Our comments on this draft state health plan are provided with those goals and will focus on specifics on policy issues, questions of clarification and perspectives that we propose be taken into consideration in drafting this State Health Plan.

AAMC leadership is aware of upcoming legislation that will propose to allow an existing acute care general hospital to convert to a Freestanding Medical Facility (FMF) on a CON-exempt basis, just as conversions to limited service hospitals are currently authorized. The proposed legislation would also re-define "hospital services" for purposes of rate regulation to include emergency services provided at a CON-exempt FMF, as well as outpatient services (determined by the HSCRC by regulation) that are provided at any FMF. If this legislation passes, AAMC believes that the Commission should revisit this State Health Plan Chapter to ensure appropriate regulatory oversight over hospital conversions to an FMF, as well as over the provision of any outpatient services in addition to emergency services at an FMF. AAMC supports requiring a CON process for the expansion or establishment of any type of FMF.

---

[1] Maryland Hospital Association – Financial Conditions and Utilization Trends Report – Period ending June 2015

[2] Maryland Hospital Association – Financial Conditions and Utilization Trends Report – Q2 2015

AAMC provides the following specific comments on the Draft Chapter:

1. Applicability. The Draft Chapter should be clarified to make clear that it applies not only to the establishment of new FMFs, but also to the relocation, expansion and/or capital expenditure in excess of the threshold with respect to an existing FMF (***including*** an FMF established prior to the effective date of the Draft Chapter). While the three existing FMFs are not required to obtain a CON to continue to operate, any relocation, expansion and/or capital expenditure in excess of the threshold should be subject to the CON requirement. This clarification is needed in Applicability (D) and Effective Date (E). In addition, the final sentence of the Introduction under .03 (page 7) should be clarified to state that CON approval is not required only for the initial establishment of the existing FMFs. Finally, General Standard A(1) and Project Review Standard B(1)(c) refers to the establishment, relocation or expansion of an FMF, but it should also encompass any capital expenditure in excess of the threshold.

2. Issues and Policies, Introduction

Reference is made to care provided "in drugstores or other types of retail settings" (p. 5). There can be confusion among urgent care, walk-in care, immediate care and convenient care. It is important to distinguish immediate care from urgent care. Immediate care is the care provided in a retail setting, in contrast to urgent care.[3]

On page 7, there is a reference to reduction of crowding at the parent hospital. While there has been discussion that opening a FMF may reduce crowding at the parent hospital, it is important to be aware that a FMF would not impact need for inpatient services. Also, the impact to the closest hospital, not necessarily a part of the health system, needs to be evaluated.

3. Access to Care

What information is available to determine the cause of: "EDs remain overcrowded with long wait times for service" conditions that ACEP reports on (as referenced on p. 8)? Will the conversion of inpatient hospitals to FMFs ease these conditions?

[3] American Association of Urgent Care Medicine – aaucm.org

4. Quality of Care

AAMC is proud to play a part in contributing to the "highest ranking in the nation for "quality and patient safety environment" as cited as a part of the American College of Emergency Physicians (ACEP) report card (p. 11). The Draft Chapter should promulgate policies that preserve our high ranking and do nothing to jeopardize our standing in the nation.

5. Rate Regulation

AAMC is concerned about the impact of long term volume shifts from FMFs on the global budgets of other hospitals, mentioned on page 12 of the Draft Chapter. This should be explicitly made a component of the "impact" standard. Additionally, in the case of a conversion of acute care services to a FMF, how will the total revenue for services not provided at the new FMF be removed from the Maryland system by the HSCRC or redistributed to facilities that absorb the volume?

6. Policy Objectives

With regard to Policy 5 (p.13), AAMC believes that additional detail should be provided. How will the primary care needs of the population be assessed? Will the locally developed community health need assessment be the source of information on the health and needs of the community? What specific strategies and tactics will be required to educate individuals and families to avoid the use of emergency services? This important responsibility should be shared with providers, health systems, payers and patients.

7. General Standards

The General Standards (p. 14) should state that an applicant for a FMF must be the "parent hospital" (as defined in the Definitions) to make clear that the applicant must be an existing acute care general hospital and may not be a multi-hospital health system.

8. Project Review Standards – Need (B(1))

The Draft Chapter is unclear on whether a CON is required to close an FMF. AAMC believes that this should be clarified.

On page 16, AAMC seeks additional clarification regarding how "inadequate access and barriers" is defined. Is the applicant hospital expected to ask local urgent care centers to bear some of the burden of the unfunded patient or just to increase their capacity to take insured

patients away from the FMF or the hospital? In some cases, the parent hospital has limited ability to impact independent practicing primary care.

On page 16 [(c)((vi)], the word "current" should precede the community health needs assessment (CHNA), as the new 3-year CHNAs are now complete.

Additionally, on page 16 [(c)(vii)], AAMC requests additional clarification as to what is meant by the "low end of the range." How will the standard be defined and applied?

On page 17 [(c)(viii)], AAMC requests further clarity around how patients may be redirected in a manner that is compliant with EMTALA.

9. Project Review Standards – Access (B(2))

On page 17 [(c)] will EMS be mandated to share data to enable the applicant to meet the requirement to "optimize accessibility for patients who are currently served in the applicant hospital's service area"? AAMC is unclear how this standard is satisfied.

10. Project Review Standards – Cost and Effectiveness (B(3))

On page 18 [(a)], the applicant bears the burden of showing two alternatives considered. AAMC recognizes that this is the same requirement as in the Acute Care Chapter, but believes that this requirement should be explored further in both contexts. This standard is often difficult and overly burdensome in its application.

On page 19 [(c)], AAMC requests additional details about the Commission's expectations on promoting coordination.

11. Project Review Standards – Efficiency (B(4))

On page 20, AAMC seeks further details about the expectation to present the analysis to the EMS on the efficiency of emergency services delivery for the patient population in the proposed or existing FMF service area.

12. Project Review Standards – Impact (B(7))

As discussed above, the impact of long term potential volume shifts on global budgets of other hospitals should be explicitly considered, as referenced on page 12 of the Draft Chapter.

The requirement that a project not have a "severe impact" on another hospital is unclear. AAMC is not aware of any other context in which a "severe impact" is the standard and it is undefined in this context.

13. Project Review Standards – Quality Improvement (B(8))

On page 23, the FMF will have to consider the impact that "competition" with its parent hospital's ED for inpatient beds will have on its ability to manage length of stay of its patients requiring hospitalization. Overcrowding in the areas hospitals will likely have a significant impact on the FMF's capacity, as it will be "holding" patients who need to be hospitalized, similar to the ED trying to provide relief. Will this be addressed? Who takes priority for bed placement?

14. Project Review Standards – Preference in Comparative Reviews (B(9))

On page 24, what is contemplated, specifically, in how the FMFs will be integrated with primary care delivery? More detail would be helpful.

Additionally, AAMC offers the following general comments on the Draft Chapter:

- General Comment 1: AAMC recognizes that urgent care centers are not currently regulated for quality or otherwise, and are under no requirement to accept patients regardless of ability to pay. Additionally, they are not required to provide indigent care. AAMC is concerned that the disparity between urgent care centers and FMFs can undercut policy objectives outlined in the Draft Chapter, in particular, ensuring access to care and a mechanism to ensure that patients are receiving care at the appropriate place.

- General Comment 2: A parent hospital may feel there is a need for a FMF, to provide more accessible and timely care to its patient population, but the costs may be prohibitive, due to the fact that the FMF will have to compete with the urgent care and retail care market, and it will be relegated to caring for patients with higher acuity (but not necessarily emergent) and indigent patients (as its ED already does).

- General Comment 3: There should be a more specific definition of FMF, with respect to services it must provide on a 24 hour/day, and 7 day/week basis. Current FMFs often transfer patients to an ED for care and diagnostic tests that should be available at an FMF. This causes additional expense and inconvenience for the patient and accepting ED. The FMF becomes a "glorified" urgent care center.

Thank you for the opportunity to provide these comments. Congratulations on your good work in addressing this pressing need in our State.

Sincerely,

Paula S. Widerlite

Paula S. Widerlite
Chief Strategy Officer